JENKS (ED. W.)

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CESAREAN SECTION AFTER SEVEN DAYS' LABOR,

WITH

SOME COMMENTS UPON THE OPERATION.

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Compliments of

Dr. Edward W. Jenks,

Detroit,

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84 Lafayette Avenue.

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THE Cesarean section is an operation so rarely performed, and under any circumstance is considered so formidable a one, as well as uncertain in good results, that the reports of cases should not, in the opinion of the writer, be withheld from the profession. It is believed that the following case possesses a special interest on account of the time which elapsed from the beginning of labor until abdominal section was made, and from the fact that the patient fully recovered under what seemed to be the most adverse circumstances.

On the evening of the 16th of June last, my friend, Dr. Flinterman, of this city, came for me in great haste, with the announcement that he wished me to perform Cesarean section upon a woman at full term, a primipara, who had been already seven days in labor in charge of women; that he had been summoned within the past hour, and found the patient quite exhausted. He further said that upon examination the left shoulder was found presenting at the brim of a rachitic pelvis, so deformed that the conjugate diameter of the superior strait did not exceed two inches. Hoping that my friend might be deceived as to the deformity of the pelvis, and that I might be able in some manner to deliver the poor woman *per vias naturales*, I suggested the taking of a full supply of embryotomy instruments. The doctor replied that he would carry all I possessed, but he was satisfied that she could be delivered in no way but by Cesarean section. Upon reaching the house I learned that seven days before the liquor amnii had been discharged; the labor-pains soon followed, and were quite severe; that they had continued with but short intervals up to the present time; that the woman's mother and several other women all concurred in the opinion that labor would terminate hap-

pily after a while; but a midwife was called in during the present day, who, discovering an arm presentation, at once sent for Dr. Flinterman. The patient, æt. twenty-four, a healthy German woman, was much enfeebled by the many days of severe pain, so that it became necessary to administer stimulants before making an examination.

Upon passing my hand into the vagina there gushed forth a quantity of putrid fluid of the most offensive character, clearly indicating that decomposition of something had taken place, but by drawing down the presenting arm there were no indications of its being the fœtus.

The woman was then etherized for the purpose of facilitating examination and making any operation we might decide upon. Examination corroborated the opinion of Dr. Flinterman as to the deformity of the pelvis. I could barely insert three fingers above the brim, but could not possibly crowd my hand beyond it, even when the woman was held upon her knees and chest; version was thus shown to be an impossibility. Fully convinced that in impacted cross-births, amputation of limbs, evisceration, or extraction of the child by piecemeal, are the most dangerous of all obstetric operations, I should not, even where instruments can be easily manipulated within the parturient canal, long hesitate between such procedure and the Cesarean section, or gastro-elytrotomy, if there was a fair chance of saving fœtal life. There are matters, however, which must be determined in each individual case, and where a general rule cannot be implicitly followed, I shall discuss this point briefly farther on in this paper.

But in this instance, putting to one side all such considerations, the angularities of the parturient canal caused by the pelvic distortion prevented any kind of instrumental delivery per vaginam, for there was no opportunity of carrying any instrument above the superior strait, and at the same time allowing a hand in the vagina as a guide. If the presentation had been a cephalic one, then perforation and cephalotripsy might have been performed.

The fœtal heart-sounds could not be heard, and although the evidence was not positive of the child's death, it was markedly presumptive. The condition of the child, whether dead or alive, not being considered, it was very apparent that it must be removed by abdominal section, or else the woman be left to die undelivered.

The apartment which the patient occupied was heated to about 80° F., when with the efficient aid of Drs. Flinterman and Torrey, I proceeded after the usual method of performing gastrotomy, first securing firm and equable pressure by the hands of my assistants upon the uterus through the abdominal walls, for the triple purpose of holding it in position, to prevent blood from the wound escaping into the peritoneal cavity, and to protect the viscera from unnecessary exposure to the air. It is needless to enter into a full description of the minute details of every step of the operation, and I only allude to the means taken to facilitate the section, and to prevent secondary troubles, as I consider them important considerations bearing upon gastrotomy for any purpose.

The incision was made from about an inch and a half above the

pubes to the umbilicus, a distance of at least seven inches, a corresponding cut was made into the uterus. The fœtus was seized by the feet and readily extracted. Pulsation in the umbilical cord had ceased, and although the child was dead, it did not present the appearance of having been so long. If the operation had been performed a few hours earlier, the child, without doubt, could have been saved, as it was fully developed and well nourished.

The placenta was adherent to the fundus of the uterus, but was readily extruded through the incision by the uterine contractions and with it came out also a quantity of the putrid fluid which had produced the horrible stench before alluded to. This offensive fluid was evidently due to clots of blood within the uterus, as there were no signs of decomposition about either the placenta or the fœtus. There were from four to six ounces of this dirty fluid, and in spite of all our precautions a small quantity escaped into the peritoneal cavity. The uterus was carefully sponged out, that no source of further decomposition might remain therein. The uterus contracted, but not sufficiently to prevent blood from escaping throughout the entire length of the incision, while particularly from the severed sinuses did it flow in a large stream.

I accordingly closed the uterine rent by four silver wire sutures, carrying them deeply into the uterine substance from lining to covering of the viscus, in hopes that during the process of involution it might be possible for them to be discharged by the uterine canal in a similar manner as is claimed are sutures put into incised or wounded intestines. The sutures were all twisted and the ends turned downward into the line of the incision. The abdominal cavity was carefully, but rapidly, sponged out, the external wound was closed by deep silver wire sutures and superficial ones of silk, and a flannel roller bandage put around the abdomen, the whole operation being completed within twenty-five minutes. The woman rallied well, and the next morning was quite comfortable. About sixteen hours after the operation her pulse was 120 and her temperature 103°, the most rapid pulse and the highest temperature attained at any time. After this, pulse and temperature subsided.

Twenty-four hours later the patient was as comfortable and apparently in no more perilous a condition than women usually are at this period of the puerperal state following the easiest of labors. Convalescence proceeded without interruption, and the woman at this time is engaged in her usual occupation of housewife, as strong and well as ever before in her life.

This closes the record of the case, and while this brief paper is in no sense intended as an essay upon gastro-hysterotomy, I cannot forbear making the foregoing narrative the text for some further remarks bearing upon it and the Cesarean operation in general.

Gastro-elytrotomy, an operation theoretically much more simple and less dangerous than the Cesarean section, might

have been performed, but I am inclined to the opinion that the thorough sponging of the interior of the uterus, thus ridding it of the products of decomposition rather than allowing them to discharge *per vias naturales*, rendered the patient less liable to putrid infection, and more than counterbalanced the possible lesser risk of gastro-elytrotomy.

The length of time this woman had been in labor would of itself, judging by the history of other cases, be sufficient to prevent her recovery from the dangerous operation she was subjected to. But upon this point we must bear in mind that the majority of women who have been operated upon after this method had previously been subjected to long-continued intra-uterine manipulations, and fruitless attempts at delivery before abdominal section was attempted, and hence the great mortality of Cesarean operation. In this case, from the fact that there were no intra-uterine manipulations (for the reason that they could not be made beyond the cervix), I think we find a satisfactory explanation of one of the most important factors of her recovery. The question might properly be discussed here—under what circumstances is the Cesarean section justifiable, when the fetus can be delivered by other means? I fully agree with one of the reviewers of Playfair's Obstetrics,[1] who writes as follows: "As long as craniotomy is practicable, it should be performed in preference to the Cesarean section. . . . . This question of craniotomy or Cesarean section in extreme cases of pelvic deformity is still *sub judice*; we doubt whether the latter operation, performed on a healthy woman and at an early stage of labor,[2] would not give a better percentage of recoveries than craniotomy, done, as is usually the case, on a patient more or less prostrated by a protracted confinement and various attempts at instrumental delivery." In transverse fetal presentations, the long and often fruitless attempts to perform version, when mutilation of the child becomes necessary before it is delivered, are as dangerous to the

[1] Dr. Mundé in American Jour. of Obstetrics, Jan., 1877.

[2] This opinion seems fully corroborated in the fact that women have been operated upon two, three, and even four times. When operated upon once, no time was lost in subsequent pregnancies in attempts to deliver *per vias naturales*. Dr. Gibson, of Philadelphia, performed Cesarean section successfully twice on the same woman.

life of the mother as the Cesarean section. In fact, it would seem as if the latter was far preferable, as it is no more hazardous for the mother and affords the only opportunity of saving the child. In England, where the Cesarean operation is held in less esteem than on the Continent, the percentage of recoveries of mothers and children saved has been much larger, when made on account of malignant disease of the womb, than when made by reason of the more common causes of deformed pelves and malpresentations. The value of timely surgical interference before the patient is exhausted is thus illustrated. In the valuable essay of Dr. Harris,[1] statistics are given clearly demonstrating this same point. He gives a table of seventeen cases, operated upon during, or at the close of the first day of labor. In all of the cases but one the child was removed alive. Of these cases $73\frac{9}{13}$ per cent. of women and $86\frac{2}{13}$ per cent. of children were saved by operating early. Can statistics of embryotomy make an equally good exhibit?

It is not long since ovariotomy has been recognized as justifiable under any circumstances, but to-day the hundreds living who but for its performance would have died, have made it a legitimate operation and placed it in its true light before the profession. If the same skill and care are applied to the Cesarean operation that have been to this, "it will then present its true measure of danger as a surgical operation, instead of the exaggerated character which it has been made to exhibit." It is possible that gastro-elytrotomy, an operation as yet in extreme infancy, may prove practically, what it is upon more theoretical grounds, a much better and safer operation than gastro-hysterotomy.

The Cesarean section has been made, so far as can be ascertained, less than one hundred times in the United States. At the time Dr. Harris's paper was published he could learn of but sixty operations, with twenty-eight deaths of mothers, while twenty-seven children were delivered alive. In Great Britain and Ireland the mortality has been greater. Are there not some means other than those already alluded to, of lessening still more the death-rate of this operation? In looking over the reports of cases we will find quite often an account of one where the uterus did not contract well after the

[1] The Cesarean Operation in the United States. By Robert Harris, M.D. American Jour. of Obstetrics, Nov., 1871, and Feb., 1872.

fetus was extracted, where bleeding continued and as a consequence the abdomen was left open a long time, until it was thought safe to close it. Two cases, at least, are on record where the uterus was removed on account of uncontrollable hemorrhage. One is by Dr. H. R. Storer,[1] whose patient died in sixty-eight hours. Another was recently reported by Prof. Spaeth[2] of Vienna, who operated under spray; the bleeding not stopping, he ligated the uterus just above its vaginal insertion, then amputated with an écraseur and brought the pedicle out of the wound. Strange to say, the patient recovered. These *may* have been exceptional cases, but it would seem as if in the majority of instances the loss of blood, long delay occasioning shock, and exposure of the peritoneal cavity to the air, are among the risks that are preventable by immediate closure of the uterine rent with sutures, either of catgut, silver, or silk. In case the hemorrhage proceeds not from the cut surfaces but from the interior of the uterus, on account of uterine inertia (which gives rise to post-partum hemorrhage in ordinary labors), then ergot should be administered hypodermically, as an additional precaution.

The advice in many obstetrical works, about being in no haste to close up the wound, but to wait until the uterus contracts, is not good surgical advice. Sutures closing up the uterine wound insure contraction, and at the same time prevent what otherwise might be a long delay, lessening the danger from shock; further, the uterine sutures prevent the escape by any straining effort of blood or lochia into the peritoneal cavity, through the uterine incisions—thus diminishing the danger of peritonitis or septicemia. I would prefer catgut or silver as the material for uterine sutures, but in the absence of either would rather use silk or linen than to make use of none. There is not that dread of leaving sutures in the peritoneal cavity which formerly existed, as every ovariotomist can testify.

I have myself left, in one case of ovariotomy, eight silk ligatures, and in another eighteen within the peritoneal cavity, without ill consequences; they have been left in large numbers by Dr. Peaslee and others, without evil results. All oper-

[1] Jour. Gynæc. Soc., Boston, Oct. No., 1869.
[2] The Clinic, Cincinnati, July 28, 1877.

ators of course prefer cases of ovariotomy where there is no need of ligatures being thus left, but still it is a fact that they are tolerated by the peritoneum. The question of uterine toleration of such innocuous substances as catgut or silver wire, is no longer an undecided one, if we may judge of their great service by the history of the limited number of cases where they have been allowed to remain. Dr. Harris says[1]: "I am disposed to believe that they do not materially add to the gravity of the operation." If the wound in the uterus contracts, after the fetus and placenta are removed, its length will not be more than two inches, but even then there is danger of secondary gaping with all its evils consequences, and hence the necessity of their use.

In my own case, the cut in the uterus was fully five inches in length when the sutures were inserted; there were no indications of immediate contraction to a safe length, and the blood poured forth in a dangerous manner; but the sutures at once arrested the hemorrhage. It would seem worse than folly to wait an indefinite length of time under such circumstances for the uterus to contract, in obedience to an old obstetrical rule, when modern experience teaches us that its breach is more to be honored than its observance. I believe the following to be a safer rule. "The application of uterine sutures after every Cesarean section will probably diminish the rate of mortality attending that operation."[2]

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[1] The Clinic, Cincinnati, July 28, 1877.

[2] Rodenstein, Amer. Jour. of Obstet., Vol. III., page 582.